REQUEST FOR PROVISION OF MEDICALLY PRESCRIBED TREATMENT (NON-MEDICATION)

DeKalb County School District

School Year 20___ to 20___

STUDENT_____ DOB_____SCHOOL_____

Part I: Physician's Statement/Order (Please circle treatment below)
(Attach prescription(s)/additional sheet(s) if necessary to provide requested information and medical authorization).

Clean Intermittent Catheterization	**Nebulizer Treatment**	**Chest Percussion (CPT)**
Gastrostomy/Jejunostomy Feeding	**Oxygen Administration**	**Postural Drainage**
Naso-Gastric Feeding	**Oral/Pharyngeal Suctioning**	**Ostomy Care**
Dressing Change	**Tracheostomy Care**	**Blood Glucose Monitoring**
Pulse Oximeter Monitoring	**Other**_____	

1. Diagnosis_____

2. Treatment required in school_____

_____

3. Specific instructions for providing treatment_____

_____

_____

4. Frequency/Time to be provided_____

5. Conditions under which treatment should not be provided_____

6. Date(s) when treatment should be initiated __ __ __ __ __ __ terminated__ __ __ __ __ __ __ __ __ __

7. Possible side effects/adverse reactions to treatment_____

_____

8. Specific instructions for non-medical school personnel in case of adverse reactions_____

_____

9. Specific instructions for nurse (if one is assigned and present) in case of adverse reactions_____

_____

_____ _____

Signature of Practitioner Licensed to Prescribe **Date**

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Permission is granted for exchange of medical information between my child's physician(s) and the special education nursing department.

_____ _____

Parent Signature **Date**